DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #03-17

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.30

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 60,000
b. FFY 2004 $660,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Page 3
Attachment 3.1-A, #6.b.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Page 3
Attachment 3.1-A, #6.b.

Kansas (03-17)
Approved: 07/11/03
Effective: 07/01/03

10. SUBJECT OF AMENDMENT:
Optometric Services Limitations

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Janet Schalansky – signature//

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary of Social & Rehabilitation Services

15. DATE SUBMITTED:
June 11, 2003

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-2210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 12, 2003

18. DATE APPROVED:
July 11, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
//Thomas W. Lenz - signature//

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists= services.

[X] Provided: 9 No limitations [X] With limitations*

Not provided.

c. Chiropractors= services.

[ ] Provided: 9 No limitations [ ] With limitations*

[X] Not provided.

d. Other practitioners= services.

: Provided: Identified on attached sheet with description of limitations, if any.

9 Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: 9No limitations :With limitations*

b. Home health aide services provided by a home health agency.

Provided: 9No limitations :With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

9No limitations :With limitations*

*Description provided on attachment.

Substitute per email dated 06/26/03.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#6.b.

Optometric Services Limitations

1. Optometric examinations are limited to one complete exam every four years.
2. Two partial exams per month are covered for the treatment of medical conditions.
3. Post-cataract surgery exams are covered, as needed, up to one year following the surgery.
4. Vision therapy is noncovered.
5. Medical care by optometrists is covered according to Kansas licensure limits.
6. Includes one pair of eyeglasses every four years.